

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2012
NAME OF PROVIDER OR SUPPLIER NIGHTINGALE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1036 S RANGELINE RD CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>This visit was for a state home health complaint investigation.</p> <p>Complaints: IN00103913 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: March 23, 2012</p> <p>Facility #: 009554</p> <p>Medicaid #: 200107010</p> <p>Surveyors: Marty Coons, R.N. Public Health Nurse Surveyor</p> <p>Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Nightingale Home Healthcare, Inc. was found to be in compliance with 410 IAC Article 17 Rule 12 Section 3 (4)(A)(B), Rule 13 Section 1(a), and Rule 14 Section 1 as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 30, 2012</p>	N 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

5JZY11

If continuation sheet 1 of 1